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FEATURE ARTICLE

Crossing borders: Discussing the evidence relating to the mental health needs of women exposed to female genital mutilation

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ABSTRACT: The terms ‘Female Circumcision’ (FC), ‘FG Cutting’ (FGC) and ‘FG Mutilation’ (FGM) refer to procedures involving the partial or total removal of the external female genitalia for non-medical reasons. In practicing countries, FGC/FC is more widely used, as it is believed to be inoffensive, providing more impartial ways of discussing the practice. Positive beliefs about FC/FGC include virginity, marriage prospects, family reputation, or passage to adulthood. Regardless of terminology, the practice exists in at least 28 African countries, and a few Asian and Middle Eastern countries. In Western society, FGM is considered a breach of human rights, being outlawed in a number of countries. With immigration trends, FGC is now prominent in Western society among practicing communities. While the past decade has seen an increase in studies and recommendations for health-care support related to the physical health consequences of FGM, little is known about the psychological impact and its management. For many girls and women, FGC is a traumatic practice, transforming it to FGM and affecting their mental health. This discussion paper focuses on evidence relating to the mental health consequences of FGM, therapeutic interventions, and the mental health nurse’s role in addressing the needs of this group of women.

KEY WORDS: female genital mutilation, intervention, mental health, nursing, psychological consequence.

INTRODUCTION

Global estimates suggest that 100–140 million girls and women have undergone female circumcision (FC) with more than three million girls being at risk of the practice each year on the African continent alone (Population Reference Bureau 2010; World Health Organization 2008). FGM is practiced in at least 28 countries in

Africa, and a few others in Asia (e.g. Indonesia) and the Middle East (e.g. Kurdistan, Yemen). However, to date, data have only been systematically collected from 27 developing countries (Population Reference Bureau 2010).

While it could be suggested that FGM is mainly a sub-Saharan problem, migration trends have played a major role in transferring cultural and traditional beliefs attached to the practice to the Western world (Johnsdotter 2004; Mathews 2011). The social convention of those originating from practicing countries is said to be strongly rooted, and relocating to Western countries does not simply change the perceptions of migrants. Rather, FGM has become a reality in Europe, Northern America, and Australia (Denison *et al.* 2009; Johnsdotter 2004;

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Mathews 2011). In England and Wales, it is estimated that there are almost 66 000 women who have undergone FGM, and 21 000 females under the age of eight will be at risk of FGM (Dorkenoo *et al.* 2007). With migration trends to the UK from sub-Saharan Africa, where FGM prevalence is high (often exceeding 95% in some areas), it is suggested that instances of FGM are significantly higher now in the UK than the estimates above, which were based on the 2001 census (Population Reference Bureau 2010).

During the past decade, there has been an increase in the number of studies focusing on the health consequences of FGM, with many denouncing the practice (Berg *et al.* 2010; Dorkenoo *et al.* 2007; Population Reference Bureau 2010; Yoder & Kahn 2008). While many of the studies are contextualized within a historical perspective, policy development, and/or procedural descriptions, there is very little documentation on the emotional repercussions of FGM. The World Health Organization (2008) referred to the emotional traumas relating to FGM, stating that the possible shame or complications are not addressed or treated by health and social care professionals. Although the psychological impact attached to the practice of FGM is described in some studies (Behrendt & Moritz 2005; Dare *et al.* 2004; World Health Organization 2006), evidence is very limited on its treatment and management.

ORIGINS OF FGM

FGM is primarily associated with Africa; however, the World Health Organization (1996) suggest that it has existed in all countries at one time or another. For example, there were several reported cases in the UK and the USA during the early 20th century, where FGM was performed by physicians to 'treat hysteria, lesbianism, masturbation and other so called female deviancies' (Toubia 1994, p. 225). There are a number of sociocultural factors that impact on the practice of FGM, particular beliefs, behavioural norms, customs, rituals, and social hierarchies inherent in religious, political, and economic systems (Momoh 2005). For example, in Somalia, there is a strong belief that FGM is a religious requirement (Keizer 2003; Nienhuis *et al.* 2008), although there is no description of the practice in the Quran or the Bible, although it was in existence prior to Christianity and Islam (World Health Organization 1996; 2006). In some practicing countries, uncircumcised girls and women are not welcome in their society. The Masai of Tanzania refuse to call a woman 'mother' if she has children and has not been circumcised (Boyle 2002, p. 36). A more common reason

for FGM, particularly for those communities living in Western society, is that of preserving a girl's or woman's virginity (Berggren *et al.* 2006; Gruenbaum 2001; Talle 2007). For women and girls brought up in Western society, who are possibly still at risk of FGM, the effects of acculturation might impact further on their mental well-being (Whitehorn *et al.* 2002).

These experiences might be even more traumatic on girls who share Western cultural norms and on whom FGM is inflicted. For some practicing communities, FGM is a way of ensuring marital fidelity and preventing sexual behaviour that is considered deviant and immoral (Abusharaf 2001; Ahmadu 2000; Gruenbaum 2001; Hernlund 2003).

The stigma inherent is likely to further compromise women's mental well-being, particularly for those who are opposed to FGM, yet resides in communities where it is part of the cultural practice.

FGM AND HUMAN RIGHTS

According to the World Health Organization (2008), FGM of any type is a harmful practice and a violation of the human rights of girls and women. Across the world, the migrant population is strongly represented by vulnerable groups of refugee and asylum seeker families, where girls and women experience various forms of gender oppression (Burnett & Peel 2001; Correa-Velez *et al.* 2005). In considering FGM as being a serious breach of human rights, the United Nations (UN) High Commissioner for Refugees and other agencies of the UN have stated that refugee and asylum status should be granted to women and girls fleeing their country to escape the practice; a statement reiterated by the British Medical Association (2008). However, globally, there are very few records of girls and women granted refugee status on the ground of FGM. In 1998, one case of successful asylum application was registered in Canada, another one in the USA, and two in Sweden (Amnesty International 1998). In 1999, one further application was registered in the USA (Amnesty International 2000). In the UK, there are no statistics available reporting successful asylum applications on the basis of FGM, while Article 3 of the European Convention on Human Rights (1984) defends the right to be free from torture and inhumane or degrading treatment (Home Office Immigration and Nationality Directorate, pers. comm., 2001). The Female Genital Mutilation Act (2003) (<http://www.legislation.gov.uk>) makes it an offence for UK national or permanent residents to carry out FGM, or to aid, abet, counsel, or procure the carrying out of FGM abroad, even in

countries where the practice might be legal (Gordon 2005). More recently, the UN General Assembly's Human Rights Committee 2012 (<http://www.amnesty.org>) placed FGM in a human rights framework, highlighting the need for a holistic approach that includes recognizing the importance of empowering women, the promotion and protection of sexual and reproductive health, and breaking the cycle of discrimination and violence (Díaz 2012).

PSYCHOLOGICAL IMPACT OF FGM

While the physical health consequences of FGM are well documented (Behrendt & Moritz 2005; Dare *et al.* 2004; Royal College of Obstetricians and Gynaecologists 2009; World Health Organization 2006), the emotional affects remain limited. The World Health Organization (2000) found that only 15% of studies focusing on the health effects of FGM considered mental health, and most of these were case reports, highlighting an important gap in the literature. Where studies on psychological consequences of FGM have been undertaken, factors, such as severe forms of FGM, immediate post-FGM complications, chronic health problems and/or loss of fertility secondary to FGM, non-consensual circumcision in adolescence or adulthood, and FGM as punishment, have all been identified as causes of distress (Lockhat 2004). Likewise, depression, post-traumatic stress (PTS), and symptoms of impaired cognition comprising of sleeplessness, recurring nightmares, loss of appetite, weight loss or excessive weight gain, panic attacks, and low self-esteem have been attributed to FGM (Behrendt & Moritz 2005; Elnashar & Abdelhady 2007; Kizilhan 2011; Osinowo & Taiwo 2003; Vloeberghs *et al.* 2011).

For many girls and women, undergoing FGM is a traumatic experience that has been found to have lasting psychological consequences (World Health Organization 2011). Undertaking a systematic review of the literature pertaining to psychological problems resulting from FGM, Berg *et al.*, (2010) indicated that there is a high probability that women who have been subjected to FGM suffer emotional disorders, such as anxiety, somatization, and low self-esteem, and are at greater risk of a mental illness. These findings were reiterated by Chibber *et al.* (2011). A controlled study undertaken by Behrendt and Moritz (2005) in Senegal compared the mental status of 23 circumcised and 24 uncircumcised females, and found that almost 80% of circumcised females met the criteria for mental illness, with 90% of circumcised women describing severe pain and feelings of intense fear, helplessness, and horror at the time of the trauma. More than

80% continued to have flashbacks, a common phenomenon of PTS (Behrendt & Moritz 2005). The present study reiterates previous findings. Lockhat (1999) conducted a study in Manchester, UK, of Somali and Sudanese women, of which 75% of participants recognized that they suffered recurrent, intrusive memories and loss of impulse control. More recently, Zayed and Ali, (2012), who conducted a prevalence study of female circumcision in Egypt, after a change in the law banning the procedure, found that 63.9% of the sample had experienced circumcision, of which 94.9% had emotional trauma. In the UK, young women receiving psychological counselling for FGM report feelings of betrayal by parents, incompleteness, regret, and anger (World Health Organization 2000). In addition, a pilot project undertaken in the UK by an African organization providing psychosocial therapy to women who have experience of FGM described the overwhelming trauma, the long-lasting emotional damage it causes, and the difficulty of suffering in silence reported by the women (New Step for African Community, 2012).

While FGM is condemned in Western society, the psychosocial implications of not undergoing FGM could adversely impact on females living in practicing communities. Not undergoing the practice could lead to a loss of cultural identity or anomie, resulting in mental distress, manifesting as anxiety due to fear of becoming socially excluded from their community. A number of studies report that women who have been subjected to FGM have minimal psychological morbidity, often feeling proud and believing that they are a better person (Chalmers & Hashi 2000; Mwangi-Powell 1999). In a study of 432 Somali women living in Canada, the participants reported memories of FGM, including intense fear, severe pain, and being seriously ill at the time of mutilation, but also having a sense of pride, happiness, and enhanced purity and beauty (Chalmers & Hashi 2000). The strong belief that a woman needs to be circumcised to be seen as good is often inherent within the culture and passed from one generation to another (Nienhuis *et al.* 2008), presenting a challenge for those in Western society, whose concern is that of mental well-being.

The complexity of FGM in the cultural context is demonstrated in a pre- and post-intervention study of 100 women undertaken by Ekwueme *et al.* (2010). Knowledge, attitudes, and behaviours pre- and post-FGM were explored. The women were recruited by systematic sampling from the General Outpatient Department at the University of Nigeria Teaching Hospital (Enugu, Nigeria). The results showed that prior to undergoing FGM, the knowledge of the respondents on the true meaning of the practice was 54%, with 70% believing that

FGM was good, and based on culture and tradition, the practice should be continued. Respondents displayed a highly-negative and stigmatizing attitude toward women who had not been circumcised; 74% said they are promiscuous, 49% said they are shameful, 14% said they are cursed/outcast, and 66% would not recommend them for marriage. After the women had been circumcised, the results showed that 85% of the respondents had a better understanding of the meaning of FGM, 71.3% knew the complications, 11% supported FGM, but 83% were against the practice. The stigmatizing attitudes held against women who had not been circumcised decreased significantly post-intervention; beliefs of women being promiscuous fell from 74% to 22%, being shameful fell from 49% to 12%, being outcast/cursed fell from 14% to 2%, and not being suitable for marriage fell from 66% to 19% (Ekwueme *et al.* 2010).

PSYCHOSOCIAL INTERVENTIONS TO ADDRESS THE EMOTIONAL CONSEQUENCES OF FGM

Although there are now extensive studies in the clinical field of psychosocial interventions for mental illnesses experienced by the black and minority ethnic (BME) population, including groups of refugees and asylum seekers (Department of Health 2005; Kieft *et al.* 2008; MIND organization 2009), there is still a lot that needs to be done to provide specific emotional support for women exposed to FGM. A number of studies (Behrendt & Moritz 2005; Elnashar & Abdelhady 2007; Kizilhan 2011; Osinowo & Taiwo 2003) have made recommendations for current psychological interventions to be adapted as a way of providing culturally-sensitive therapy. However, studies reporting on the implementation and evaluation of psychological interventions, specifically addressing the needs of women who have experienced or who are at risk of FGM, are limited.

The limited research relating to the psychological consequences of FGM, coupled with the nuanced context of tradition and cultural beliefs, will impact on the way in which mental health services might provide support for women exposed to the practice. When developing therapeutic interventions for women exposed to FGM, deep-rooted beliefs in the practice of FGM need to be taken into account, as well as the cultural and social pressures women from practicing communities are likely to experience.

A successful therapeutic relationship is fundamental to good mental health care (Cleary 2003; Warne & McAndrew 2005). To promote healing, cognisance needs to be taken of both the physical consequences of FGM

and the cultural issues surrounding it in order to provide sensitive care (Daley 2004). A number of countries, such as the UK, Germany, Belgium, and Sweden, have established guidelines on FGM for medical providers (Nour 2004; British Medical Association 2011); however, little attention has been paid to effective interventions addressing psychological needs (MIND organization 2009). Only one study, which was carried out in the Netherlands (Vloeberghs *et al.* 2011), looked at participants' experiences of mental health provision. The results of that study indicated both positive and negative experiences. Positive experiences indicated that their interactions with mental health services were positive, as practitioners were better informed about circumcision and were aware of its existence in the Netherlands. Participants also reported positive interaction with doctors and nurses when in the reception centre (for asylum seekers and refugees), with mental health professionals showing understanding, providing correct information, and referring women to appropriate services to address specific problems (Vloeberghs *et al.* 2011).

In the UK, current mental health provision for asylum seekers and refugees includes a limited number of specialist services for asylum seekers located in trusts or run by independent bodies or trauma services, including survivors of torture or violent conflicts in their patient population. These include Freedom from Torture (formerly the Medical Foundation for the Care of Victims of Torture), interagency partnerships (developed specifically to provide services for this group), and specialist general practices of in-house sessions with community mental health nurses or counsellors (Aspinall & Watters 2010). Drawing on an evaluation of the impact of the introduction of a community psychiatric nurse in a large refugee camp, Kamau *et al.*, (2004) argued that even a small amount of mental health care can have a dramatic impact on the mental well-being of refugees. However, Ward and Palmer (2005) found that only five of the 11 mental health trusts based in London provide specialist services that are specifically designed with the needs of refugees and asylum seekers in mind. They also found that, with the exception of a small number of primary care trusts, there appears to be a general lack of awareness that refugees and asylum seekers are a group that have distinct needs, which are multiple, complex, and require specialist knowledge. In these circumstances, the effectiveness of psychological interventions for mental health difficulties can be compromised, and especially for those at risk of FGM, whose cultural beliefs are at odds with the legal system of the country they are now residing in.

MAKING SENSE OF THE EVIDENCE

While there are only a small number of empirical research studies on the psychological consequences of FGM, what is evident is that the mental health of women who have undergone or who are at risk of FGM will be compromised (Behrendt & Moritz 2005; Chibber *et al.* 2011; Elnashar & Abdelhady 2007; Kizilhan 2011; Nnodum 2002; Osinowo & Taiwo 2003; Vloeberghs *et al.* 2011). Common mental illnesses, such as affective disorder, anxiety, and somatization (Behrendt & Moritz 2005; Chibber *et al.* 2011; Elnashar & Abdelhady 2007), were evident for women who have undergone FGM, and have implications for those mental health professionals working in primary care. In addition, it would appear that women exposed to FGM are more likely to report symptoms commensurate with PTS, and in particular, recurrent flashbacks (Behrendt & Moritz 2005; Chibber *et al.* 2011; Kizilhan 2011), the latter being more common among women exposed to more severe forms of FGM (Lockhat 2004).

Regardless of the type of FGM and its psychological consequences, Berg *et al.* (2010) reiterated the importance of considering the fact that the practice is culturally embedded; this might well form a protective factor against the emergence of psychological distress in its aftermath. Berg *et al.* (2010) suggested that future research should take the possible protective element of FGM into account when examining the short- and long-term psychological consequences of the practice. Alternatively, it has been suggested that FGM should be viewed as a social convention, and the taboo surrounding the practice might account for why women do not complain about their emotional distress after circumcision (Vloeberghs *et al.* 2011). However, Behrendt and Moritz (2005) argued that despite the fact that FGM constitutes a part of their participants' ethnic background, the results of their study implied that cultural embeddedness does not protect against the development of PTS and other mental illnesses.

Coping strategies are also important to consider when developing services for those exposed to FGM. In their study, Vloeberghs *et al.* (2011) explored coping factors, and concluded that both support seeking and avoidance-coping styles appear to be associated with higher levels of anxiety and depression. Vloeberghs *et al.* (2011) identified four categories of women: the adaptive woman, the religious woman, the disempowered woman, and the traumatized woman, and provided information about women's ways of coping in terms of whether or not they seek support. Their findings showed that 'adaptive'

women were able to cope with their problems, which were mainly physical and of a sexual nature. 'Religious' women also revealed that they knew how to deal with their problems related to FGM and preferred not to talk about it, considering sexuality as a private matter. This group reported less fear and depression than non-religious women. The 'disempowered' women's behaviour was prone to emotional reticence, anger, and defeat. In refusing to talk about their experience of FGM, they developed negative ways of coping, developing problems, such as substance misuse, binge eating, excessive television watching, and sometimes serious mental illnesses. Hidden tension and a fatalism tendency were characteristics of these women. Finally, 'traumatized' women (i.e. mostly women who had been infibulated) appeared to be either divorced or in a bad relationship, and had a lot of pain and sadness. Within this group, there was a higher incidence of psychological problems, including recurrent memories, sleep problems, chronic stress, and higher levels of anxiety and depression.

TRANSLATING THE EVIDENCE INTO PRACTICE

Holistic approaches taking into account sociocultural factors (Department of Health 2009; Ward & Palmer 2005) could contribute to a better understanding of the psychological traits of women exposed to FGM, whether they remain in practicing countries or have migrated to Western countries, ensuring valuable resources are directed to those at greatest risk.

While it is important for mental health professionals to demonstrate adequate knowledge and awareness of the origins, traditions, and psychosocial implications of FGM (Utz-Billing & Kentenich 2008; Whitehorn *et al.* 2002), it is equally important to put the acquired knowledge into practice through the use of sensitive, therapeutic approaches that address the needs of women who have been circumcised.

There appears to be limited research relating to psychological interventions for women who experience negative consequences of FGM. To date, talking about psychological interventions for those exposed to FGM is limited to recommendations and guidance on how to provide adapted, existing emotional support (Applebaum *et al.* 2008; Behrendt & Moritz 2005; Elnashar & Abdelhady 2007; Kizilhan 2011; Vloeberghs *et al.* 2011; Whitehorn *et al.* 2002). In her doctoral thesis, Jones (2010) explored the theme of FGM and clinical psychology in London and the south of England. Jones's study was divided into two parts. The first part comprised

semistructured interviews to explore the views and experiences of six women who had undergone FGM in relation to their use of clinical services. The second part comprised questionnaire results of 74 surveyed qualified clinical psychologists working in a range of specialities regarding their experiences, knowledge, and training needs in relation to FGM. The findings from part one of the study showed that what participants wanted from clinical psychologists was for them to have knowledge about how the practice is accounted for (e.g. the reasons for it and the contexts within which it exists), and that psychologists should facilitate conversations about FGM during consultations by asking questions and responding in a sensitive and non-judgemental manner. Finally, they wanted clinical psychologists to validate and respect their experiences, rather than consider it a 'cultural matter' that should be avoided.

Part two of the findings highlighted minimal experiences and knowledge of FGM among the clinical psychologists, and the need for a variety of training in order to increase their confidence in working with women who have experienced FGM. Although there was a small sample of participants in the first part of the study, it demonstrated some overlap between the two groups, particularly with regards to the lack of awareness among clinical psychologists and how this has the potential to compromise the provision of emotional support for this group of women. In light of this, Jones (2010) made some strong recommendations for the improved knowledge of FGM within clinical practice. The findings from the study are pertinent for such knowledge to be common among mental health nurses, as they are often on the frontline, and more likely than psychologist to be the first point of contact for women exposed to FGM.

Using therapeutic interventions that facilitate acceptance, as well as change, are said to foster resilience and well-being (Linehan 1993). Radical acceptance, and in the case of FGM, cultural connections, need to be considered and acknowledged during the healing process. This approach was initially proposed by Linehan (1993) in her biosocial theory and the interaction between these two factors. For example, Linehan's 'invalidating environment' theory could equate to the family's rejection of the uncircumcised woman, and her consequential fear of expressing emotional feelings related to FGM. An acceptance of this situation on the part of the nurse might facilitate psychological therapeutic understanding of FGM and could help alleviate a woman's distress. Incorporating a biosocial approach might assist in acknowledging the reasons for the practice and the contexts within which it occurs, as well as providing an opportunity to

validate and respect the women's experience, rather than dismissing it as a cultural issue. In addition, therapeutic intervention needs to be dialogical in nature. In order to achieve a flow of meaning that brings understanding to the person's experience, listening is essential; in doing so, culture, family, and the immediacy of the situation is contextualised (Bohm 1996; McAndrew 2013).

As previously indicated, there has been minimal research and/or evaluation of the effectiveness of interventions that have been developed to meet the emotional needs of those who have experienced FGM. The majority of women who have been exposed to FGM will be from an asylum seeker or refugee background, and as such, could potentially make use of the limited number of specialist services available for BME communities (Department of Health 2005; Kieft *et al.* 2008; MIND organization 2009), while waiting for a more appropriate therapeutic interventions to address their special needs. In the UK, specialist services, which include trauma services for survivors of torture or violent conflicts, are delivered by the Freedom from Torture organization. However, these specialist services exclude victims of FGM, as they do not meet the organization's criteria. Freedom from Torture considers torture as 'Any act by which severe pain or suffering, whether physical or mental, is intentionally inflicted on a person for such purposes as obtaining from him or a third person information or a confession, punishing him for an act he or a third person has committed or is suspected of having committed, or intimidating or coercing him or a third person, or for any reason based on discrimination of any kind, when such pain or suffering is inflicted by or at the instigation of, or with the consent or acquiescence of, a public official or other person acting in an official capacity', as defined by Article 1.1 of the United Nations General Assembly (1984) (<http://www.freedomfromtorture.org>). FGM does not fit within this definition, although it has been recognized as a violation of the human rights of girls and women (World Health Organization 2008). FORWARD, a major international organization campaigning for the human rights of women from practicing communities, aims to change policy and practice regarding FGM. At a local level, other organizations exist, for example, New Steps for African Communities and the Greater Manchester FGM Forum, with whom health professionals can collaborate in raising awareness on the implications of FGM. The majority of people accessing help from Freedom from Torture are those who are tortured during conflicts, where torture is used to introduce a climate of fear and to force people to flee (<http://www.freedomfromtorture.org>). Other services that might provide interventions would include specialist

general practices that provide in-house sessions with community mental health nurses or counsellors (Aspinall & Watters 2010). However, like the psychologists in Jones's (2010) study, they also might need tailored training in order to support women exposed to FGM.

PROVIDING MENTAL HEALTH CARE IN A MULTICULTURAL WORLD

As the world becomes intensely close, complex, and multicultural, cultural awareness and transcultural care are becoming increasingly important (Seisser 2002). In keeping with the ethos of transcultural nursing, mental health nurses are required to provide culture-specific and universal care that promotes the health and well-being of people by enabling them to face unfavourable human conditions, illness, or death in culturally-meaningful ways (Leininger & McFarland 2002). To achieve this, nurses need to be prepared in transcultural nursing by being able to identify culturally-vulnerable populations, and to develop professional competencies that will enable them to address their needs (Leininger & McFarland 2002). It is important that mental health nurses can identify cultures that are neglected or misunderstood in order to help health-care systems assess how they serve, or fail to serve, diverse cultures in local communities (Seisser 2002; Wenger 1999). To achieve transcultural nursing, Leininger (2000) emphasised the need for research that focuses on discovering largely-unknown and vaguely-known cultural care and health concerns from two perspectives: the emic perspective (focusing on the local, indigenous, and insider's culture) and the etic perspective (focusing on the outsider's world, with an emphasis on the professional view).

In keeping with such transcultural developments in health care, the New Step for African Community (NESTAC) project, referred to earlier, started gathering evidence from those who have experience of FGM; some of them describing the long-lasting emotional implications FGM has had on their lives (New Step for African Community 2012). More recently, NESTAC has secured funding for a collaborative 3-year project, under their wellbeing programme, with the University of Salford. The wellbeing centre is a community-based programme, mainly supporting refugees and asylum seekers by attending to their sociocultural needs. The new project, called Support Our Sisters (SOS), is developing a specialized service for cognitive and emotional support, aiming to provide three FGM drop-in clinics and accredited training for peer mentors. SOS project is established in areas with a high prevalence of women from FGM-practicing

communities across Greater Manchester. For the purpose of this programme, an existing model of transcultural therapy (Kieft *et al.* 2008) benefiting refugees and asylum seekers has been adapted for women affected by or at risk of undergoing FGM. It is anticipated that this project will add to the small but growing body of knowledge relating to mental health nurses addressing the emotional effects of FGM, and the types of interventions that are most effective in alleviating the distress experienced by many women who undergo this practice.

CONCLUSION

While tradition and culture play a central role in the practice of FGM, it is nevertheless a breach of women's human rights that impacts on their mental and physical well-being. It would appear that the number of studies relating to the psychological consequences of FGM remains low compared to the considerable number of research studies on the physical and sexual consequences of FGM, suggesting that more needs to be done if the mental health needs of this group of women are to be appropriately met. It is evident that young girls and women who have undergone FGM are more likely to have psychological consequences than those not exposed, and that the level of distress is likely to be determined by important factors, such as the severity of FGM, the socio-cultural context, and their psychological predisposition. While research solely exploring the psychological aspects of the different types of FGM should be sought, specialist education and training that takes into account these factors have the potential to provide mental health professionals with a greater understanding of the issues facing women from practicing communities. Globally, transcultural nursing is a facet of the 21st century, and while the sociocultural aspects of FGM bring an associated complexity in addressing the needs of this group of women, mental health nurses, often the first point of contact, are best placed to explore how service provision can be improved. Moreover, there is an urgent need for further research in regards to the types of psychological interventions that would be sensitive and appropriate for women from the FGM-practicing communities if mental health nurses are to meet the psychological health needs of a high proportion of the estimated 100–140 million girls and women worldwide who have undergone FGM.

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